Introductory Questionnaire and Chair Conversation Summaries

Education and Mental Health Coordinating Council | September 17, 2021

Below are summaries drawn from council member responses to the Education and Mental Health Coordinating Council Introductory Questionnaire.

1. **What are three or four measurements currently in use that give accurate information about the mental health of children and youth of our state?**
   - Wellness checks by pediatricians
   - Pediatrician records
   - Youth suicide rates, including: attempts, ideation, deaths
   - ACE survey
   - SHARP survey
   - Youth Outcome Questionnaire (YOQ)
   - Ages and Stages (ASQ)
   - SafeUT
   - Crisis line data
   - Public K-12 schools: dropout rates, discipline data, climate surveys, information from mental health workers in schools
   - CPS referrals and removals
   - Behavioral health screenings
   - Peer mentoring at the postsecondary level
   - Good collection of mental health and wellness data in some pediatric offices
   - Self-harm data
   - BRFSS
   - Data from Child Mind Institute
   - Police reports
   - SEEK survey
   - Domestic violence rates

   Other thoughts:
   - There are good tools for general mental health screening, but there is variation in implementation and how the results are used. Also, tools and results aren't being applied the same way across different fields
   - There aren't good measures for young children, in part because there aren't good standards for defining mental health in younger children

2. **What are a couple of measurements you wish we had to provide accurate information about the mental health of children and youth of our state?**
   - Hospital admissions
   - Medicaid information
   - Mental health checkup data (annual screening similar to a well child screening)
   - Universal screeners for students as early as elementary school, as early as kindergarten
   - Better measures for family and child engagement and functioning
   - Standardized social determinant screening tool (for example: SEEK, DLA, etc.)
   - Ages and stages social emotional development
   - Agreed upon measurements across sectors
   - Insurance rates by age
   - Estimated children in the state with a serious mental illness (like estimates available for adults)
   - ACEs information by age and geography
   - Expulsions from childcare/early education settings

Other thoughts:

- It could be useful to have domestic violence/abuse measurement
- Is it possible to transfer information (e.g., student IEP) from K-12 to postsecondary systems?
- Shift terms from measuring "mental health" to measuring "wellness" and "wellbeing"
- Not an issue of "what are the best screeners." The goal is to pick up the kids not being identified, and the best, most compatible services available should inform the screening approach
- The state needs a more thoughtful, integrated approach to identifying kids to connect their needs with appropriate, evidence-based treatments

3. **Are there areas where you think the following organizations provide duplicative services: (1) local education agencies (LEAs), (2) local mental health authorities, (3) local substance abuse authorities, and (4) private health care and mental health care providers?**
   - Tier 1/general prevention and Tier 2/targeted services: Overlap between schools, private providers, after school programming, etc. Juvenile justice/DCFS is also doing some early intervention services for some referrals
   - Tier 3 services: Some overlap between schools – psychosocial groups, clinical interventions, etc. – and mental health providers
   - At times tension – or turf war – between county health department and school system
   - Probable overlap between MCOTs/SafeUT and community organizations, colleges/universities

   Other thoughts:
   - There will always inherently be duplicative services. The issue isn't as much redundancy but translating well across different settings

4. **Are there areas where you feel lack of communication within or between different organizations (LEAs, local mental health authorities, local substance abuse authorities, private health care and mental health care providers) is impeding the provision of good care?**
   - Lack of coordination between sectors, like multiple forms and data systems that could be streamlined
   - Families have to sign too many releases
   - Lack of common language between organizations, providers, etc.
   - Requirements for HIPAA, FERPA, etc.
   - Lack of working relationships in local communities. Particularly, poor communication between school and community-based services
   - No common platform for providers to work from
   - Higher education systems could do better with cross referencing resources
   - Mental health/wellness tracked in pediatric settings does not connect to other systems (schools, behavioral health, etc.)
   - Need shared language for trauma between pediatricians and mental health professionals
   - Big gap between physical and mental health information available between the Medicaid, CHIP, and ACO systems
   - Challenging for PCPs to determine referrals in clinical environment (how/who)
   - Difficult to share data for children's care – communication is costly
   - No screening for trauma and mental health in young children

Other:

- Communication is key, but the system actively punishes cross-communication efforts

5. **Are there areas where there are gaps in services that leave our children, youth, and families in difficult situations?**
   - Not enough mental health service providers, particularly licensed providers for children (LCSW, child psychiatrists, etc.)
   - Some mental health providers don't accept insurance
   - Transitions between agencies, particularly schools. When students are receiving intensive services, schools often are unaware of the needs and how to support students.
   - Lack of culturally appropriate and responsive services for those with health disparities and from marginalized communities
   - High acuity needs in local communities, integrated care for co-occurring needs (substance use, mental health, intellectual disabilities, and physical health care), and early intervention approaches
   - When a young adult enters college, they tend to seek out more services (independence from parents), but it's difficult to coordinate services provided privately and those at an institution
   - PCPs are very good at screenings, but handoff/referral process to behavioral health specialists is very challenging and fee for service does not reward the physician
   - Navigating behavioral health system is extremely complex
   - Birth – 5: pediatricians, day care, and childcare providers lack awareness of mental/social/emotional development
   - Lack of tracking mechanisms for preschool and childcare suspensions and expulsions
   - General lack of access for early intervention and prevention services
   - Lack of providers trained in infant and early childhood mental health
   - No true crisis care for young children
   - Acceptance of Medicaid is not widespread
   - Full-day kindergarten to increase availability of services for children and families

   Other:
   - There is inconsistent access to evidence-based outpatient services
   - For higher levels of care, there are big discrepancies based on where the person lives. Some children and youth are stuck with a "something is better than nothing" approach rather than the right service or provider for the right person
   - Tighter restrictions on prescribing practices. Conversations about prescriptions for psychotropic drugs need to happen along with conversations about lack of access other to evidence-based practices and interventions
   - Wraparound services and community school models provide one place where families can receive services

6. **Can you think of five or more ways the state already spends money on programs the state has enacted or spends money on in an effort to benefit the mental health of children and youth of our state?**
   - Crisis lines
   - Help Me Grow
   - Support for endorsement system (Alliance for the Advancement of Infant Mental Health)

- Public K-12 system: school nurses; Mental health workers to schools (HB 373, 2019); training school resource officers on child development and mental health (HB 345, 2021); special education services; mental health screenings (HB 323, 2020)
- Early childhood: preschool funding, funding for autism and therapeutic preschools; early childhood mental health grants (HB 337, 2021); state childcare programs; school readiness mentor coaches; early childhood specialists
- Medicaid and CHIP
- The Children's Center
- JED Foundation (colleges and universities)
- MCOTs
- Peer mentorship
- ABC model (Antecedent-Behavior-Consequence)
- Nurse-family partnership
- Juvenile justice reform and day skills programs (HB 239, 2017)
- Telehealth funding
- Project AWARE
- GLS grants
- SafeUT
- Stabilization and mobile response
- Nurse family partnership
- Maternal mental health programs
- App based tools have been very valuable – not just for tool itself but for conversation around mental health they create
- Child protective services and foster care system
- Baby watch early intervention and Baby Your Baby
- State higher education system to train health professionals
- SNAP and WIC benefits
- State services for people with disabilities
- Medically complex children's waiver
- Primary Children's Medical Center, including pediatric psychiatric inpatient beds and services
- State services for post-partum depression
- Intergenerational poverty initiative
- ORS program to enforce child support payments
- The state is the pass through for TANF (for example, state nurseries that are a last for families)
- Developmental center in Utah County
- The state requires insurers to cover autism treatment
- The state pays for PKU formula for children who need it

7. **When thinking about programs on which the state spends money or ways in which the state uses resources to benefit mental health of children and youth in our state, which are the top few programs where you feel it would be beneficial to direct additional resources?**
    - School nurses
    - Medicaid
        - Finding and enrolling people
        - Sufficient benefit package to access necessary services
    - Improve pipeline for more mental health workers (scholarships and incentives)
    - More resources in the birth through 5 year-old space
    - Training and support in mental health issues for pediatricians
    - Earlier interventions, particularly where children are already going (schools, child care, afterschool)
        - Better coordination between primary care and schools/childcare/after school programming

    - Integrate behavioral health in those spaces
- Workforce development – pay current workers more and develop the pipeline. (There was a big upheaval in the healthcare workforce during the pandemic)
- Friends of the Children
- Social/emotional/brain health education in schools
- More school-based wraparound services
- Office of Childcare
    - Early childhood mental health consultation
    - School readiness mentor coaches
- DSAMH – Therapeutic Preschool Program
- DCFS staff – needs more resources to retain an experienced workforce
- Domestic violence shelter funding
- Full-day kindergarten

8. **Are there any programs that currently do not exist in Utah that you feel would benefit the mental health of the children and youth in our state that could be adopted and funded?**
    - Improving school-based health systems
    - Expanding peer mentorship program to more college/university campuses
    - Reflective supervision
    - Statewide early childhood mental health screenings
    - Statewide definition of early childhood expulsion
    - Supports for social-emotional learning in young children
    - Combined home visiting and trauma-informed early childhood mental health model (such as Child First)
    - Healthy Steps pediatric model
    - Be Well, Care Well (childcare workforce support program)
    - Statewide full-day kindergarten

9. **What are some policy changes that do not involve spending money that you think would be beneficial for the mental health of the youth in our state?**
    - Destigmatize mental health issues by improving school-based health instruction and including mental health information
    - Requiring ACE survey at child wellness visits
    - Mandatory student health insurance (college/university)
    - Standards for the workforce providing services in schools, as staff may be over or underqualified for the training they are providing
        - Types of services provided
        - Levels of licensure required
        - Training and education requirements
    - Data sharing standards and policies to help with communication and outcome gathering.
    - Improve interagency alignment through MOUs/MOAs with standards for partnering with policies and procedures on access to care and shared youth/families
    - Common outcome measures used across providers and systems
    - Culturally relevant outreach and education
    - Birth through age 2:
        - Align DSM 5/ICS 10 with DC 0:5 for children under 6 years, and eliminate the requirement of a mental health diagnosis to provide services

    - Money spent on training should be vetted by an approved panel of experts in IECMH to ensure alignment with best practices
- Preschool:
    - Align DSM 5/ICS 10 with DC 0:5 for children under 6 years. Allow billing with DC 0:5, including Z codes
    - Frame expulsion priorities within IECMH principles. Tie efforts to reduce or ban expulsion with enhanced coordination of services to support childcare centers

10. Please identify the most effective promotion or education program(s) around the importance of mental health of the state's children and youth?

- Healthy Utah (although it doesn't include much mental health)
- Adding mental health workers to schools
- New partnership with Huntsman Mental Health Institute (HMHI) will create new opportunities
    - E.g., PSA video competition with Huntsman/Student Life groups/Sundance Film Festival to break down mental health stigma
- SafeUT
- QPR
- Psychological First Aid
- Universal mental health screening in schools
- Social emotional learning programs in schools
- Botvins Life Skills (older grades)
- Hope Squads
- Guiding Good Choices
- Parents Empowered
- Health Steps (promotion-based part of the model)
- Center of Excellence for Infant and Early Childhood Mental Health Consultation resource (SAMHSA funded)
- ZTT materials for babies, and Framework Institute's position messaging
- Sesame Street Community efforts at promoting early childhood mental health (trauma, racism, etc.)

11. What ideas do you have to improve promotion or education around importance of mental health of the state's children and youth?

- School-based training
- Something similar to Healthy Utah with a focus on mental health
- Training for early learning providers, teachers, etc. in recognizing mental health issues in children
- Improving the domestic violence shelter system
- Legislative support for social emotional learning (SEL) programs that are being politically hijacked. Proactively teaching self-regulation and mental resilience have an impact on mental health
- Statewide campaigns: Better results when statewide campaigns are tied to public health promotion and prevention efforts and coordinated with local mental health and substance abuse authorities, local health department, the state board of education, local education agencies, or infant and early childhood providers and committees
    - Pattern after programs like "Baby Your Baby" or "Immunize by 2"
- Use Parents Empowered to educate parents on protective factors for helping with mental health specific needs
- Better education on infant and early childhood mental health for all healthcare providers

- Training and reflective supervision for early childhood providers to help them 1) recognize mental health issues, 2) have the skills to address it, and 3) have the support to digest the challenges that come from engaging in the work

12. Should the Education and Mental Health Coordinating Council consider anything else not addressed here?

- Lots of mental health service access points for children have been shifted into schools, which has moved the workforce. One concern that this has created is school social workers not always working at the top of their licenses – working on issues that could be resolved by a less- or unlicensed individual
    - Not necessarily a bad thing, just difficult to connect to medical resources (liability, insurance, getting kids medication when necessary, etc.)
- Statewide survey of mental health professionals and childcare providers to better understand their needs
- Statewide survey of parents and families across Utah to better understand mental health needs
- Work with parents and pediatricians to increase understanding of the social and emotional needs of children
- Focus on gathered outcomes across systems to ensure the services are benefitting kids and families
- Early childhood space is a challenge for mental health
- There has been a lack of certainty around education and parent employment during the pandemic and issues of social isolation for children
- There are organizations doing research on mental health access for minority populations in the state (for example, Latina Behavioral Health Services and Polynesian Research Group). While not specific to children and youth, their work could be relevant to the Council
- Childcare support: Without widespread financial support for childcare centers, our society will crumble. Caregivers of children with mental health challenges often cannot find suitable childcare and are left without ability to work
    - Retaining childcare workers is a challenge because of burnout and other challenges. This means it is difficult to retain sufficient staff to keep enough centers open (at best). Worst case scenario is that the quality of care suffers because of stress and lack of necessary training
- Health insurance does not cover necessary treatments
- Fund hotspots and other required equipment and services to access telehealth options
- Bill codes for mental health treatment for children under age 6 and parents
- Better funding for the following programs:
    - ABC
    - CPP
    - Safe Baby Court Team (currently one pilot for Utah County, just beginning second year). Broad adoption of this incredible model can transform state's child welfare system
    - The Alliance's Competency and Endorsement system is in Utah (Alliance for the Advancement of Infant Mental Health). Broad support will provide state a way to distinguish providers who are trained in and aligned with IECMH principles